MAP – Guidance for Criterion 3: Significant Event Analysis

Assessors find this a very interesting section to mark because it tells them so much about the candidate. The ability to take a long hard look at notable things which have happened in our professional lives; how we learn from them; and how we make changes is incredibly important.

It is essential that the event involved the candidate. It is not enough to have sat in an SEA meeting, unless you are directly involved in suggesting and implementing change. It might be one which affected your own practice or your area of responsibility such as the staff, trainees or salaried doctors. If you are a locum or a salaried doctor it is more likely that it will need to be about your own clinical practice unless you played a major role in the plan which is put into place. SEA is an invaluable tool for looking at the process of what happened and improving quality of care, not looking for scapegoats.

The first step is to find out what actually happened by talking to everyone involved. Then look at what went wrong and at which stages of the event problems arose. Then make a plan to put things right.

The event must have occurred within five years at the date you submit this criterion for assessment.

If possible tell us how this has worked since you put it into place. There are seven headings in the portfolio proforma, *use them*. They ask for what has changed in the practice but also what has changed in your personal practice as a result of the event.

The difference between serious incidents and significant events can sometimes be confusing. The GMC document Supporting Information for Appraisal and Revalidation 1 refers to serious incidents as significant events. A subsequent footnote clarifies that in general practice significant event audits are used to describe what the GMC refers to as case studies and/or events. These may not have had a serious outcome but highlight issues that could be handled with greater clinical effectiveness and patient safety, and from which lessons could be learnt. If a doctor is involved in a serious incident (i.e. one with patient safety concerns), it should be included as a significant event in the portfolio.